U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LOIS M. VEHRS and U.S. POSTAL SERVICE,
POST OFFICE, Bangor, WA

Docket No. 03-398; Submitted on the Record;
Issued March 27, 2003

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issue is whether appellant has more than a four percent permanent loss of use of her right arm.

On January 19, 1995 appellant, then a 44-year-old clerk, filed a claim for an occupational disease for right tennis elbow. The Office of Workers' Compensation Programs accepted that her right elbow tendinitis was causally related to her employment.

On February 8, 1998 appellant filed a claim for an occupational disease, carpal tunnel syndrome and tendinitis. The Office accepted that her right carpal tunnel syndrome and the carpal tunnel release surgery performed on April 30, 1998 were causally related to her employment.

By decision dated February 29, 2000, the Office found that the position of modified clerk, to which appellant returned on December 4, 1999, represented her wage-earning capacity and that she had no loss of wage-earning capacity.

By letter dated May 6, 2000, appellant's attorney requested that the Office act on her claim for a schedule award. By letters dated May 23 and September 28, 2000, the Office advised appellant of the evidence needed to establish her entitlement to a schedule award.

Appellant submitted a report dated October 16, 2000 from Dr. Guy H. Earle, a Board-certified family practitioner, setting forth his history and findings on examination. Dr. Earle diagnosed right carpal tunnel syndrome, which he stated was fixed, stable and ready for rating. He also diagnosed tendinitis of the right lateral elbow, which he stated was an ongoing active disease process that resulted in significant strength loss of approximately 60 percent deficit. Dr. Earle recommended further assessment of appellant's right elbow tendinitis by the Seattle Hand Group, which the Office authorized.

In a report dated November 28, 2000, Dr. William F. Wagner, Jr., a Board-certified orthopedic and hand surgeon at the Seattle Hand Surgery Group diagnosed "mobile wad tendinitis with a possible radial tunnel syndrome" and stated that appellant had no evidence of lateral epicondylitis on examination. On February 27, 2001 Dr. David P. Tempest, a Board-certified physiatrist, performed a nerve conduction study and electromyogram (EMG), which he stated were normal with "[n]o evidence of right [m]edian or [u]lnar neuropathy from above elbow to hand." Dr. Tempest also stated: "The borderline prolongation of the palm-to-wrist segment of the Median nerve does not appear significant when compared to the [u]lnar value, especially since there was a previous [c]arpal [t]unnel surgery at this site."

In a report dated April 9, 2001, Dr. Earle stated that his examination of appellant that day revealed no obvious gross focal atrophy or swelling of the forearms and hand musculature with "tenderness and a cord-like feeling of the most distal four centimeters. of the brachial radialis tendon." He found significant qualitative decrease in forcible pronation and supination strength, as well as grip strength, right compared to left. Grip strength on the dynamometer of 12/10/13 killogram (kg) on the right versus 25/25/23 kg on the left and pinch testing of 3.5/4.0/3.5 kg on the right versus 4.5/4.5/5.0 on the left. Dr. Earle found a full active range of motion at the elbows, wrists and fingers; normal two-point discrimination in the ulnar and median distributions of the fingertips; and "some distinctly decreased sharp touch sensation in the right thumb and index fingers of both digital nerves and middle finger radial digital nerve." Dr. Earle diagnosed right carpal tunnel syndrome, post-surgery, with mild sensory residuals and chronic tendinitis of the right forearm. Dr. Earle stated:

> "Residual impairment is rated using the 4th ed. [of] the American Medical Association, *Guides to the Evaluation of Permanent Impairment.* With respect to residuals of the carpal tunnel, there is sensation alteration based on decreased sharp touch in the right thumb, index finger and radial digital nerve of the middle finger. The combined sensory value of these nerves, based on Table 16-15 is 32 [percent] of the upper extremity. [Appellant] manifests a mild Grade 4 sensory loss per Table 16, [p]age 10, rated at 10 [percent] sensory deficit. Multiplying these two produces a four [percent] upper extremity impairment due to residuals of the carpal tunnel syndrome.
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> "The impairment due to chronic forearm tendinitis is addressed using Table 16-34 for strength loss. Strength testing with the Jaymar dynamometer does meet validity criteria. There is a 52 [percent] strength loss index comparing the right side vs. the left side. Table 16-34 would award this a 20 [percent] upper extremity impairment due to strength loss.
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> "Finally, combining 20 [percent] forearm impairment due to strength loss and a 4 [percent] impairment due to carpal tunnel syndrome produces a 23 [percent] upper extremity impairment with respect to amputation at the shoulder level as residuals of this occupational disease."

On June 25, 2001 Dr. Kenneth Sawyer, an orthopedic surgeon, reviewed the medical evidence as an Office medical consultant and stated that there should be no schedule award because the electrodiagnostic testing was negative, the reported physical findings were

objectively normal with the only abnormal findings being subjective pain and tenderness Dr. Sawyer said the A.M.A., *Guides* provide that tendinitis is not ratable without specific complications such as postoperative weakness.

On June 27, 2001 an Office medical adviser reviewed the medical evidence and stated that appellant's "right forearm tendinitis is not part of the accepted condition that I can see" and that the only accepted condition was right carpal tunnel syndrome with surgical release on April 30, 1998. He noted that Dr. Earle seemed to consider right lateral epicondylitis as a part of the claim and rated it according to loss of grip strength, which was inappropriate since the condition was limited by significant pain and should not be used. Rating only appellant's right carpal tunnel syndrome, the Office medical adviser concluded that appellant had a four percent permanent impairment of her right arm, based on her mild Grade four sensory loss.

In response to an Office request to comment on the Office medical adviser's opinion, Dr. Earle stated in a July 12, 2001 report, that if epicondylitis was not an accepted condition, it should not be rated. He stated that if one ignored the grip strength decrease due to the tendinitis problem, which the Office stated was an unaccepted condition, appellant still had loss of pinch strength in the median nerve distribution that was not due to problems in the elbow. Dr. Earle rated the strength loss impairment solely due to the carpal tunnel syndrome at two percent.

On December 3, 2001 the Office issued appellant a schedule award for a four percent permanent loss of use of her right arm.

The Board finds that the Office improperly rated appellant's permanent impairment of the right arm.

The schedule award provisions of the Federal Employees' Compensation Act[1] and its implementing regulation[2] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

The Office's schedule award for a four percent permanent loss of use of the right arm was based solely on residuals of appellant's right carpal tunnel syndrome, specifically a sensory loss in the fingers and thumb.[3] This appears based on the mistaken assumption of the Office medical adviser that forearm tendinitis was not an accepted condition. The record reflects, however, that the Office accepted right elbow tendinitis in this claim.

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] Appellant's attending physician, Dr. Earle and the Office medical adviser who reviewed his report agree that this constitutes a four percent permanent impairment of appellant's right arm.

This Office medical adviser also stated that epicondylitis (and presumably tendinitis) should not be rated according to loss of grip strength "since the condition seems limited by significant pain" and cited as support the first paragraph of page 508 of the fifth edition of the A.M.A., *Guides*. This paragraph states, in pertinent part: "Decreased strength *cannot* be rated in the presence of decreased motion, painful conditions, deformities or absence of parts (*e.g.*) thumb amputation) that prevent effective application of maximal force in the region being evaluated."[4] (Emphasis in the original.) However, Dr. Earle's reports do not indicate that the decreased strength in appellant's hand related to her forearm tendinitis is the result of a painful condition that prevents effective application of maximal force.

Dr. Sawyer's opinion that no schedule award should be issued for tendinitis because the A.M.A., *Guides* specifically state it is not ratable without specific complications such as postoperative weakness is also not an appropriate basis for denying a schedule award for tendinitis. The section of the fifth edition of the A.M.A., *Guides* to which Dr. Sawyer refers, states: "Although these conditions [tendinitis, fasciitis or epicondylitis] may be persistent for some time, they are not given a permanent impairment rating unless there is some other factor that must be considered."[5] In appellant's case, the other factor that must be considered is that, according to Dr. Earle, her forearm tendinitis has caused a permanent loss of grip strength. The case will be remanded to the Office for further development of appellant's schedule award claim.

The December 3, 2001 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to the Office for action consistent with this decision of the Board.

Dated, Washington, DC
March 27, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

[4] A.M.A., *Guides*, 5th ed., section 16.8a.

[5] A.M.A., *Guides*, 5th ed., section 16.8b.